

## 9. Clinic Services.

## Maternity Clinic Services.

Subject to the specifications, conditions, limitations and requirements established by the single state agency, payment will be made for maternity clinic services as defined at 42 CFR 440.90 and elsewhere when provided to eligible recipients by approved providers.

- A. Covered maternity clinic services include but are not necessarily limited to risk assessment, medical services, laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling and patient education regarding maternal and child health.
- B. As a condition for receiving payment for maternity clinic services, the services must be determined by a licensed physician (MD or DO) to be reasonable and medically necessary for the care of an eligible pregnant woman (patient) during the patient's prenatal period and subsequent 60 day post partum period.
- C. The physician prescribing the services must be directly affiliated with the clinic either by employment or by a contractual agreement/ formal arrangement with the clinic to assume professional responsibility for services provided to the clinic patients.
- D. The physician must see each patient and prescribe each patient's plan of care.
- E. The plan of care must be based on a risk assessment. The risk assessment must be based on findings obtained from a health history, laboratory/screening services and a physical examination. Criteria for assessing the patient's risk is established by the single state agency.
- F. The level of services provided to the patient must be commensurate with the risk assessment and be available to patients experiencing a normal or high risk pregnancy.
- G. Covered services must be provided to outpatients by the physician or by licensed, professional clinic staff under the direction of the physician. The physician and professional clinic staff must be licensed by the state in which the services are provided. Services provided by the professional clinic staff must be within the staffs' scope of practice as defined by state law.
- H. Although the physician does not have to be present in the clinic during all hours covered services are provided, the physician must assume professional responsibility for the services provided in the clinic and must ensure these services are medically appropriate and

A	
STATE	78
DATE REC'D	10/22/88
DATE APVD	
DATE EFF	

TN No. 88-21

Supersedes

Approval Date JAN 18 1989

Effective Date OCT 01 1988

TN No. See HCFA-179

in conformance with the plan of care. The physician must spend as much time in the clinic as is necessary to assure that patients are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.

- I. Clinics must have arrangements for referral of non-stress test (NST), sonography, and amniocentesis for high-risk patients.
- J. A provider of maternity clinic services must:
  1. Be a facility that is not an administrative, organizational or financial part of a hospital.
  2. Be organized and operated to provide maternity clinic services to outpatients.
  3. Comply with all applicable federal, state and local laws and regulations.
  4. Employ or have a contractual agreement/formal arrangement with a licensed physician(s) (MD or DO) who assumes professional responsibility for the services provided to the clinic's patients.
  5. Adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of Health, unless otherwise specified by the single state agency.
  6. Ensure that services provided to each patient are commensurate with the patient's medical needs based on the patient's risk assessment, plan of care and physician direction and are documented in the patient's medical records.
  7. Be enrolled and approved for participation in the Texas Medical Assistance Program.
  8. Sign a written provider agreement with the single state agency or its designee. By signing the agreement, the maternity clinic agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee, and
  9. Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

TN No. 88-21

Supersedes

Approval Date JAN 18 1989Effective Date OCT 01 1988TN No. See HCFA-179

STATE	TX
DATE REC'D	NOV 29 1988
DATE RECD	JAN 18 1989
DATE REC'D	OCT 01 1988
DATE REC'D	88-21

A

- K. As a condition for receiving payment for services other than maternity clinic services which are covered under the Texas Medical Assistance Program, a maternity clinic, as the provider, must meet the same conditions of participation as any other provider of the same services(s) and is subject to the qualifications, limitations and exclusions in the amount, duration and scope of benefits and all other provisions specified in this state plan and elsewhere.

STATE	<u>TX</u>	A
DATE REC'D	<u>NOV 29 1988</u>	
DATE APP'D	<u>JAN 18 1989</u>	
DATE EFF	<u>OCT 01 1988</u>	
HCFR 179	<u>88-21</u>	

TN No. 88-21

Supersedes

Approval Date JAN 18 1989Effective Date OCT 01 1988TN No. See HCFR-179

## 9. Clinic Services (continued)

## Tuberculosis (TB) Clinic Services

Subject to the specifications, conditions, limitations, and requirements established by the single state agency or its designee, payment will be made for TB clinic services to eligible recipients by approved providers.

A. Covered TB-related clinic services include: physician consultation and evaluation; lab, x-ray, and diagnostic procedures (which permit the presumptive diagnosis of TB and include services to confirm the presence of infection); health history, evaluation, assessment, and record maintenance; treatment and prevention services including counseling and education for prevention and curative therapy, transmission and risk factors; prescribed drugs; case coordination; monitoring of clients for compliance to and completion of regimes of prescribed drugs including services to directly observe the intake of prescribed drugs and baseline drug toxicity checks.

B. Providers of TB-related clinic services must:

(1) Be a facility that is not an administrative, organizational, or financial part of a hospital;

(2) Be organized and operated to provide TB-related services;

(3) Comply with all applicable federal, state and local laws and regulations;

(4) Employ or have a contractual agreement/formal arrangement with a licensed physician(s) (M.D. or D.O.) who assumes professional responsibility for the services provided to the clinic's patients;

(5) Adhere to the guidelines issued by the Texas Department of Health, under the authority of the Texas Health and Safety Code and ensure that services are consistent with the recommendations of the American Thoracic Society and the Centers for Disease Control and Prevention;

(6) Ensure that services provided to each patient are commensurate with the patient's medical needs based on the patient's assessment/evaluation, diagnostic studies, plan of care, and physician direction and are documented in the patient's medical records;

TN No. 94-10  
Supersedes \_\_\_\_\_ Approval Date MAY 09 1996

TN No. SUPERSEDES: NONE - NEW PAGE

STATE	<u>Texas</u>
DATE REC'D	<u>MAR 31 1994</u>
DATE APP'D	<u>MAY 09 1996</u>
DATE EFF	<u>JAN 01 1994</u>
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(7) Be enrolled and approved for participation in the Texas Medical Assistance Program;

(8) Sign a written provider agreement with the single state agency or its designee. By signing the agreement, the TB-related clinic agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and

(9) Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

STATE <u>Texas</u>	A
DATE REC'D <u>MAR 31 1994</u>	
DATE APPV'D <u>MAY 09 1996</u>	
DATE EFF <u>JAN 01 1994</u>	
HCFA 177 <u>94-10</u>	

TN No. 94-10  
Supersedes Approval Date MAY 00 1996 Effective Date JAN 01 1994

TN No. **SUPERSEDES: NONE - NEW PAGE**

10. Dental Services.

Not provided.

STATE	<u>TX</u>	A
DATE RECD	<u>NOV 29 1988</u>	
DATE APPLD	<u>  </u>	
DATE CTT	<u>OCT 01 1988</u>	
HCFA 179	<u>88-21</u>	

TN No. 88-21  
Supersedes  
TN No. See HCFA 179  
Approval Date JAN 18 1989 Effective Date OCT 23 1988

## 11.a. Physical Therapists' Services.

Subject to the specifications, conditions, requirements, and limitations established by the Single State Agency, physical therapy services, which include necessary equipment and supplies, provided by a licensed physical therapist are covered by the Texas Medical Assistance Program. A licensed physical therapist is an individual who is a graduate of a program of physical therapy approved by the Commission on Accreditation in Physical Therapy Education, and who is licensed by the Texas State Board of Physical Therapy Examiners or other appropriate state licensing authority.

To be payable, services must be within the physical therapist's scope of practice, as defined by state law; and be reasonable and medically necessary, as determined by the Single State Agency or its designee. Therapy must be prescribed by a licensed physician (M.D. or D.O.) and performed under a plan of care developed by the physician and/or physical therapist. Covered services also include the services of a physical therapist assistant when the services are provided under the direction of and billed by the licensed physical therapist. Therapy to maintain function once maximum benefit has been reached, or to promote general fitness or well being is not a benefit of the program.

Licensed physical therapists who are employed by or remunerated by a physician, hospital, facility, or other provider may not bill the Texas Medical Assistance Program directly for physical therapy services if that billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the physician, hospital, or other provider (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the licensed physical therapist. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the services, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.

STATE <u>Texas</u>	A
DATE REC'D <u>2-23-90</u>	
DATE APPV'D <u>6-1-90</u>	
DATE EFF <u>1-1-90</u>	
HCFA 179 <u>90-06</u>	

TN No. 90-06Supersedes \_\_\_\_\_ Approval Date 6-1-90 Effective Date 1-1-90TN No. 88-21

11.b. Occupational Therapy.

Not provided.

STATE	<u>TX</u>	A
DATE REC'D	<u>NOV 23 1988</u>	
DATE APP'D	<u>NOV 23 1988</u>	
DATE EFF	<u>OCT 01 1989</u>	
HCFA 179	<u>88-21</u>	

TN No. 88-21

Supersedes

TN No. See HCFA-179

Approval Date JAN 18 1989

Effective Date NOV 23 1988

- 11.c. Services For Individuals With Speech, Hearing, And Language Disorders  
(Provided By Or Under The Supervision Of A Speech Pathologist Or  
Audiologist).

Not Provided.

STATE <u>TX</u>	A
DATE REC'D <u>NOV 29 1988</u>	
DATE APPE'D <u>JAN 18 1989</u>	
DATE EFF <u>OCT 01 1988</u>	
HCFR 179 <u>88-21</u>	

TN No. 88-21

Supersedes

TN No. See HCFA-179

Approval Date JAN 18 1989

Effective Date OCT 01 1988

## 12.a. Prescribed Drugs.

Prescribed drugs are limited as follows:

- A. To qualify for payment the original prescription must be presented within 10 days from the date prescribed.
- B. Each eligible recipient is entitled to a basic number of prescriptions each month.\*
- C. As many as five refills may be authorized by the prescriber, but the total number authorized must be dispensed within six months of the date of the original prescription subject to State and Federal laws for controlled substance drugs.
- D. The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. The State will cover new drugs of participating manufacturers (except excluded/restricted drugs) for six months after Food and Drug Administration approval and upon notification by the manufacturer of a new drug. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of drugs in emergency situations.
- E. No payment will be made for drugs in hospitals, nursing facilities and other institutions where those drugs are included in the reimbursement formula and vendor payment to the institution.

\* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

TN No. 91-33

Supersedes

TN No. 91-13Approval Date JAN 22 1992Effective Date JAN - 1 1992

STATE	<u>Texas</u>
DATE REC'D	<u>JAN - 9 1992</u>
DATE APPV'D	<u>JAN 22 1992</u>
DATE EFF	<u>JAN - 1 1992</u>
HCEA 179	<u>91-33</u>

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